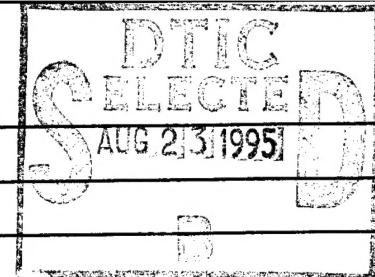


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**THE OPERATIONAL ART OF EMPLOYING U.S. MILITARY MEDICAL ASSETS
IN SUPPORT OF UNITED NATIONS PEACEKEEPING OPERATIONS (U)**

by

Sidney D. Rodgers
Commander, Medical Service Corps, United States Navy

A paper submitted to the Faculty of the Naval War College in partial satisfaction of the requirements of the Department of Operations.

The contents of this paper reflect my own personal views and are not necessarily endorsed by the Naval War College or the Department of the Navy.

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16 May 1995

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ABSTRACT

Near-term political prospects for peace in Bosnia are uncertain at best. In the interim, the 34,000-strong United Nations Protection Force (UNPROFOR) personnel in Bosnia, Croatia, and Macedonia continue UN-mandated peacekeeping efforts to contain the conflict, monitor truce provisions, facilitate humanitarian relief efforts, and prepare for the potentiality of an UNPROFOR withdrawal from this theater of operations.

Although the role of military medicine is not normally uppermost in the mind of the unified or operational commander, U.S. military medical assets can be used as an effective tool to achieve the commander's objectives in peacekeeping operations (PKOs). It is therefore important that operational level planners understand how military medicine can contribute positively in multi-national PKOs as well as in achieving U.S. strategic policy goals.

This paper examines the operational considerations in supporting the health service requirements of UNPROFOR while acknowledging the dynamic factors of operational level planning. Not only does the commander have critical areas of concern but the UNPROFOR Commander has them as well. The focus is on shaping the U.S. military medical role and realizing a synergistic unity of effort with UNPROFOR in establishing and maintaining a robust theater medical strategy. The discussion includes practical constraints on the operational design of utilizing U.S. military medical assets in support of UN-sponsored PKOs as well as the medical problems that a large, diverse, multinational peacekeeping force would face.

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PREFACE

Operational art is a critical link between strategy and policy which allows for the effective, sequenced and synchronized employment of one's own forces and assets. Operational art is concerned with both theory and practice of planning, preparing, conducting, and sustaining major operations and campaigns to accomplish operational and/or strategic objectives in a theater.¹ Therefore, the essence of medical operational art is the planning and employment of U.S. military medical assets to maximize their contribution to the combatant commander's intent. U.S. doctrine has defined peacekeeping operations (PKOs) as "military or paramilitary operations that are undertaken with the consent of all major belligerents, designed to monitor and facilitate implementation of an existing truce and support diplomatic efforts to reach a long-term political settlement."² The United Nations is the most frequent sponsor of PKOs.

SCOPE AND TIMEFRAME OF THIS PAPER

Although the U.S. Hospital Zagreb is still performing its vital mission, the scope of this paper will focus on the timeframe pertaining to the deployment and employment of Navy Fleet Hospital Six from March 1994 to August 1994. This timeframe is relevant because: (1) the U.S. Hospital Zagreb would have been operational within United States European Command's (USCINCEUR) area of responsibility (as the supported CINC) for just over 18 months and the Navy (through CINCUSNAVEUR) was commencing the sequential manning requirement; and (2) each service component commander would have therefore supported the JTF and UNPROFOR in the provision of medical care. The operational lessons learned from the CINC, the service component commanders and the Joint Task Force perspectives are abundant within this timeframe of study.

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CHAPTER I

INTRODUCTION

THESIS

Participation by member nations in the United Nations' peacekeeping effort through their provision of forces to UNPROFOR reveals varying levels of military force sizing, training, equipment, and logistics; as well as interoperability limitations, thereby lessening operational effectiveness and weakening the command and control elements. One area of weakness has been the provision of health services to the approximately 34,000 multi-national personnel assigned to UNPROFOR. The theater medical care is sporadic, lacks well-equipped and trained medical personnel, and suffers from major shortcomings, including the lack of dedicated aeromedical evacuation assets and no standard medical communications net. Additionally, U.S. military medical participation in UNPROFOR since October 1992 will serve to spearhead the development of medical doctrine to support peacekeeping efforts by shifting the present doctrinal paradigm beyond just providing combat casualty care. U.S. military medicine has a unique opportunity to increase its doctrinal fund of knowledge, thereby supporting the deliberate planning process with the publication of medical annexes and operational lessons learned. U.S. military medical doctrine could additionally be intertwined with the efforts of the United Nations to refine the latter's medical concept of operations. Operational design and the medical theater functional areas are basics of operational art that can be synopsized and adapted to peacekeeping operations.

ROLE OF U.S. MILITARY MEDICINE IN THE "NEW WORLD ORDER"

U.S. military medical units and personnel will continue to be deployed around the world in support of national security objectives. The opportunity to medically support and exploit the challenges of UN peacekeeping operations will create the environment to sustain the U.S. military health services system as a flexible system prepared to meet the challenges which lie ahead. Unprecedented advances in "jointness" have been realized around the world to support and carry out the national agenda.

What has emerged in the crafting of our National Security Strategy is the indisputable recognition that the interests of this nation remain global in nature, while the threats we face are more diverse. U.S. military medicine must be prepared to play an integral role in supporting this strategy of engagement and enlargement. Additionally, medical support must continue to evolve to allow for greater diversity of operations. Medical units and personnel increasingly are participating in multinational humanitarian, peacekeeping or peacemaking missions. One such example, the focus of my paper, is the deployed field hospital, known as U.S. Hospital Zagreb, operating continuously in Croatia in support of UNPROFOR since November 1992. (In October 1992, the UN Secretary General requested a U.S. field hospital to support UNPROFOR. On 13 October 1992, the U.S. Secretary of Defense authorized the deployment of a 60-bed hospital, followed four days later by the USCINCEUR deployment order. On 15 November 1992, the Army's 212th MASH was operational in Zagreb).

This contingency field hospital in Zagreb has been sequentially manned (in 179-day deployments) by the U.S. Army, Air Force and Navy. It has an inpatient capacity of 60 beds (30 for acute care and 30 for minimal care holding and recovery), two operating rooms and x-ray and

lab capabilities. It also has a blood bank with frozen blood and a telemedicine hookup to medical consultants in the United States. They are truly deployed in the combat theater.

THE CHALLENGE OF HEALTH SERVICE SUPPORT TO PEACEKEEPING OPERATIONS

Health service support is a significant challenge during PKOs for the following reasons: (1) peacekeeping forces normally do not have adequate organic medical support; (2) continuity of medical support functions may be difficult because of continuous unit rotation; and (3) forces are often in remote locations far from lines of communication making medical resupply, patient evacuation, hospitalization, and hospital services difficult and slow.¹ Additionally, joint medical planning and execution is critical because of the multinational composition of the forces, the expected medical mission, anticipated changes to the mission based on political and military considerations, the commander's plan, the medical threat (analysis of the medical threat ensures the medical assets are adequate for the needs of the deployed forces), and the peacekeeping force mandate/mission.

The health service support "package" for PKOs is specifically tailored to meet the needs of, and be compatible with, the size of the supported force. The health services support must be coordinated to ensure synchronization and unity of effort resulting in the elimination of unnecessary redundancies as well as the confirmation of total force coverage. Overall medical requirements are also incorporated into the support package based on the following elements (not all inclusive): type and provision of care (both inpatient hospitalization and outpatient); logistic links for resupply; mass casualty planning; aeromedical evacuation parameters; medical threat information; and preventive medicine support (environmental disease, field hygiene and sanitation).

CHAPTER II

THE "MAJOR CAST" WITHIN THE THEATER OF OPERATIONS

JOINT TASK FORCE PROVIDE PROMISE FORWARD (JTF PP (FWD))

JTF PP (FWD), headquartered at Camp Pleso in Zagreb, was formed with the primary mission of commanding all U.S. forces in Croatia and Bosnia. The JTF PP (FWD) serves as the U.S. contingent command within UNPROFOR as well as the U.S. representative to UNPROFOR, United Nations High Commissioner on Refugees (UNHCR), U.S. Embassies, and international relief agencies. JTF PP (FWD) is additionally prepared to receive HQ JTF Naples should the U.S. or NATO deploy forces into Bosnia-Herzegovina.

UNPROFOR AND THE UNPROFOR FORCE MEDICAL OFFICER (FMEDO)

UN involvement in the Former Republic of Yugoslavia (FRY) comprises three functional areas: Civil Affairs (political, diplomatic, and humanitarian); Civil Administration (support of UN infrastructure); and the UN Protection Force (the military arm). Military responsibility is divided among Croatia and its contested areas (known as Sectors North, East, South, and West); Bosnia-Herzegovina (B-H); and the Former Yugoslav Republic of Macedonia (FYROM). UNPROFOR's HQ is located in Zagreb.

UN Chain of Command: Under the UN structure, the UN Command Surgeon is known as the Force Medical Officer (FMEDO), who works under the UNPROFOR Chief of Logistics and Administration. In each of the Sectors and FYROM, the FMEDO deals through a Sector Medical Liaison Officer (SMEDLO) who is from one of the multinational country participants.

U.S. Chain of Command: All U.S. personnel in the FRY are part of Joint Task Force

Provide Promise. An interesting organizational relationship reveals that as the senior U.S. officer on the UNPROFOR staff, the FMEDO also reports to CINCUSNAVEUR in an ADDU relationship. However, by July 1994, the U.S. did not fill the next billet as FMEDO. The incoming FMEDO was Norwegian; there have been no known coordination problems nor degradation of medical capabilities; his knowledge of UN medical issues has been superb.

The UNPROFOR FMEDO branch may be considered a joint U.S. staff serving on the world's largest combined staff, whose mission is to coordinate medical treatment, evacuation, logistics and field hygiene support for UNPROFOR forces in accordance with UNPROFOR Force Commander's Policy Directive Number 20, entitled "Medical Support."¹ The UNPROFOR FMEDO serves as the medical advisor to the Force Commander and exercises functional control of all Force medical assets.

The echelon levels of medical care established and provided by UNPROFOR medical units are as follows: Level 1 / Battalion Level, provided by contingent nation whose capabilities vary by country; Level 2 / Sector Level, where field surgical teams (FSTs) provide limited surgical capability and Sector Medical Liaison (SMEDLO) officers provide limited command, control and communications; and Level 3 / U.S. Hospital Zagreb, with overall excellent surgical and resuscitative capabilities and limited aeromedical evacuation provided by using utility aircraft of opportunity.

The UNPROFOR FMEDO deals with a myriad of operational constraints and challenges, all of which effect U.S. Hospital Zagreb directly in the operational environment, and include: multiple countries and languages; damaged infrastructure (poor road system); variable to non-existent civilian medical care and public health; movement restrictions (multiple factional

checkpoints and multiple international borders); isolated UNPROFOR units and observation posts; adverse terrain and weather; infrequent but severe trauma; and communications for medical information and aeromedical evacuation requests hampered. Operational design must incorporate these constraints when attempting to develop a coherent and integrated theater-wide medical plan and policy.

Additionally, the FMEDO's medical areas of emphasis include FST standardization (capability and equipment); blood for FSTs; mass casualty planning guidance; water quality (testing, evaluation and treatment procedures); increasing use of UN logistics system (streamline SOPs); and improving medical communication (lack of a medical net). As the only Level III facility, U.S. Hospital Zagreb plays a critical health services role in supporting UNPROFOR. It should be noted, although perhaps obvious, that coordinating this medical support to such a large and diverse force is vastly different from supervising health care delivery in a Continental United States-based military hospital.

PRIVATE VOLUNTEER ORGANIZATIONS (PVOs) & NONGOVERNMENTAL ORGANIZATIONS (NGOs)

Although the UNPROFOR Force Medical Officer, the FSTs and the U.S. Hospital Zagreb are not manned or equipped to provide humanitarian aid, it does in fact occur. All non-eligible personnel may be given emergency life and limb saving treatment until they can be transferred to local host-government medical facilities. Massive amounts of humanitarian assistance have flowed into the area from UN agencies, foreign governments, private volunteer organizations (PVOs) and non-governmental organizations (NGOs). Relief efforts have focused on providing food, medical supplies, shelter and infrastructure support. Dozens of involved organizations and

agencies have included the World Health Organization, UNICEF, Medicine Sans Frontiers from Holland, European Community Medical Task Force, the International Rescue Committee, and USAID.² Additionally, during the fall of 1993, a USAID health team was sent to determine the availability and appropriateness of pediatric facilities in the Croatia and Bosnia-Herzegovina areas as well as to assess the need for the existing U.S. Hospital Zagreb to expand its mission to include pediatric services (USCINCEUR, through JCS concurrence, did not augment U.S. Hospital Zagreb with pediatric support in the form of specialized pediatric staff or equipment for routine medical care; however, the mission was modified to authorize treatment for seriously wounded Bosnian children).

CHAPTER III

U.S. HOSPITAL ZAGREB AND U.S. NAVY FLEET HOSPITAL SIX

Fleet Hospital Six was commissioned on Friday, 11 Feb 1994, in order to staff an echelon three hospital in support of Operation Provide Promise and UNPROFOR. The preliminary planning began in November 1993 when USCINCEUR tasked CINCUSNAVEUR with the mission to relieve USAFE's 48th Air Transportable Hospital (ATH) in Zagreb no later than 8 April 1994.

THE OPERATION ORDER

CINCUSNAVEUR released its operation order (OPORD) to deploy U.S. Navy personnel to U.S. Hospital Zagreb on 18 January 1994. This OPORD, derived from an earlier CINCUSNAVEUR planning order, defined the mission, outlined the concept of operations for the hospital and its sustainment, and tasked various units to support the mission.

Situation/background: As mentioned earlier, in October 1992, the UN requested the U.S. to deploy a field hospital to Zagreb, Croatia to provide medical treatment support for UN personnel. On 15 November 1992, the 212th MASH became operational in Zagreb. The personnel from the 212th MASH were replaced by the 502nd MASH on 22 April 1993. On 9 October 1993, the 502nd MASH was replaced by the USAFE 48th ATH. On 18 March 1994, lead elements of the 48th ATH would have served 179 days in Zagreb and needed to redeploy to their home base of operations.

Assumptions: Several assumptions remained at the forefront, and they included: (1) the UNPROFOR infrastructure would remain in place; (2) the scope of the UN operation and the

U.S. Hospital would remain the same; (3) commercial surface and air transportation into Zagreb would continue to be available; (4) the current level of UN provided support to Camp Pleso would continue (waste removal, power, telephone, POL, food service); and (5) all equipment currently in Zagreb, either belonging to, or in support of the hospital, would remain in place (As stated earlier, the first unit to assume the mission was the Army's 212th Mobile Army Surgical Hospital (MASH). The 212th was a USCINCEUR theater asset that established a 60 bed field Hospital at Camp Pleso, using standardized deployable medical system equipment furnished by the USAF).

Mission: USCINCEUR continued its mission to maintain a deployed 60 bed hospital along with support personnel and required equipment in Zagreb, Croatia. Thirty (30) of those beds were designated minimal care or holding beds for UNPROFOR personnel pending repatriation in Zagreb. U.S. Hospital Zagreb continued its mission to provide medical support to UNPROFOR personnel in accordance with UNPROFOR Force Commander's Policy Directive No. 20. CINCUSNAVEUR was tasked to source, coordinate and deploy appropriate medical, engineer, and associated support forces to Zagreb, Croatia to relieve the 48th ATH.¹

Execution/concept of operations: The following four phases described the planning and execution of this operation:

PHASE I: PRE DEPLOYMENT -- fleet hospital training and JTF PP (FWD) orientation was completed. A contingency follow-on element was trained in order to staff U.S. Hospital Zagreb to its maximum bed capability in the event of a crisis response. A U.S. Navy medical liaison officer was deployed to JTF PP (FWD) to facilitate reception and transition planning through PHASE III deployment of U.S. Navy personnel.

PHASE II: DEPLOYMENT -- airlift planning and load dates were established and main body and crisis augment staging areas were determined.

PHASE III: EMPLOYMENT -- Fleet Hospital Six would perform the mission for up to 179 days. JTF PP would monitor employment and exercise U.S. oversight. During Phase III, USCINCEUR and components would continue Phase I plans to relieve U.S. Navy personnel in September 1994. Additionally, the designated standby contingency personnel augmentation requirements were identified and passed to USCINCEUR to source within European assets. When directed, these augmentees would report to JTF PP (FWD) within 48 hours to staff hospital to maximum bed capacity (60 beds).

PHASE IV: REDEPLOYMENT -- 3 September 1994 would mark the 179th day for the Fleet Hospital Six advance party. Phase IV would be complete upon submission of an after action report and retrograde of U.S. Navy personnel.

Taskings to supporting elements were also included in the OPORD, for example, COMSIXTHFLT: continue primary casualty receiving and treatment ship support; COMFAIRMED: provide rear area logistics, rear area hospitalization, rear area preventive medicine personnel; HQ USAFE: continue tactical/strategic aeromedical evacuation support; HQ USAREUR: continue Class VIII resupply via US Army Medical Material Center Europe; and USCINCTrans: provide strategic airlift of personnel in accordance with JOPES TPFDD.²

Command: USCINCEUR was the supported U.S. commander and the supporting U.S. commander to UNPROFOR. JTF PP (FWD) provided command, less operational control of the U.S. Hospital. UNPROFOR provided operational control over hospital operations through the UNPROFOR Force Medical Officer.³

THE DEPLOYMENT ORDER

The deployment order was issued by CINCUSNAVEUR on 21 February 1994 for U.S. Navy personnel to relieve the USAFE 48th ATH.

OPERATIONAL CONSIDERATIONS

Mission: The primary mission of this 60-bed surgical hospital was the provision of echelon III medical care to all UNPROFOR personnel (at the time of the fleet hospital deployment, the force numbered approximately 28,000 personnel representing 24 countries speaking 14 different languages). Additionally, the hospital was to provide a comprehensive range of emergency, outpatient and inpatient health care services to the UN peacekeeping forces and other eligible beneficiaries in accordance with UNPROFOR Force Commander's Policy Directive No. 20.

Operational parameters (which became the operational statement derived from the primary mission) were several: (1) perform up to 40 surgical operations within a 72-hour window before requiring crisis augmentation; (2) in close coordination with the FMEDO and the CJTF PP (FWD), assist with medical evacuation of UNPROFOR personnel, provide on-site field medical, educational, training and technical assistance to UNPROFOR medical officers and units, in particular the management of cardiac and traumatic emergencies; (3) provide planning, technical, and physical assistance to the FMEDO on a job-by-job basis. Activities in support of the FMEDO included medical liaison and aeromedical evacuation teams; preventive medicine support and public health; assist the Zagreb SMEDLO; HQ clinic support; and the Zagreb mass casualty plan and disaster management; (4) provide liaison and coordination with PVOs and NGOs in the use of the U.S. Hospital Zagreb for the treatment and evacuation of refugee

casualties; and (5) provide emergency medical care to children as the result of a pledge made by Secretary of State Warren Christopher to the International Organization of Migration (IOM) and the UN High Commissioner for Refugees (UNHCR).⁴

Operational medical concerns were similar to and overlapped with the UNPROFOR FMEDO's issues discussed earlier, and were presented and "turned over" from prior U.S. Hospital Zagreb units. Additional concerns for Fleet Hospital Six included the policy on eligible patients; preventive medicine support; materiel resupply and blood program; continuum of care; UNPROFOR medical organization command and control; and holding, treatment, aeromedical evacuation, regulating and repatriation of patients. Lastly, up to ten (10) beds were made available for severely injured Bosnian children.⁵

Although the primary mission was to provide third echelon medical care to all UNPROFOR personnel, shortcomings to mission accomplishment within the operational parameters were realized early on. There was (1) no functioning, theater medical plan; (2) an apparent lack of basic medical care for some foreign contingents; (3) a disjointed Sector Medical Liaison program; (4) as many evacuation plans as contingents; and (5) no dedicated aeromedical evacuation assets. Command imperatives mandated no additional risk to U.S. medical personnel and no additional mission resources were available.⁶

FLEET HOSPITAL SIX OPERATIONAL ASSESSMENT AND ACCOMPLISHMENTS

In a generic sense, full mission performance was revealed in a high volume of outpatients (7959 of which 50% were Emergency Room visits and 25% Physical Therapy) and surgical procedures (230 operations), steady inpatient caseload (297 admissions of which 49% were disease related & 51% injury), care of refugee children, support of the refugee camps and

continuous Sector Medical Liaison visits (88 hospital personnel involved in 39 missions).⁷ Major issues were in a continual state of refinement and they included command and control relationships; relationships with the UNHCR, IOM, PVOs and NGOs; and lastly, a common PKO problem, mission creep, in the form of pediatric and preventive medicine support.

Sector Medical Team Activities provided a superb bridge from the construct of operational design to the tactical provision of medical care in support of the operational requirements within the theater. Salient points of the Sector Medical Teams revealed that they evolved early out of need to provide medical focus and a personalized service to the medical needs of other UNPROFOR nations. They permitted an assessment of quality and quantity of medical care in the sectors, allowed continuous first-hand knowledge of sector medical problems, and enlarged the pool of observation and ideas. Sector Medical Teams were reinvigorated, direct assistance to SMEDLOs was provided as well as to nation contingents by providing concrete teams for the SMEDLOs to contact, the provision of transport teams for aeromedical evacuation was bolstered, the provision of the most timely medical care possible in the theater was facilitated, and the SMEDLOs were prepared to deal with potential mass casualty situations in their sector. With the tendency to view the provision of medical care as a common task, this served as an excellent lesson on integration and interoperability.⁸

The sector liaison and medical augmentation teams "external missions" programs derived from these exigencies and was astonishingly successful. This program was vital to the functioning of the U.S. Hospital Zagreb as an integral member of UNPROFOR. There were many important products of the program, and one of the most important was the assurance to the physicians in the field that the U.S. Hospital was there to help them. Perhaps now that sector

activities have become the *status quo ante*, the command hierarchy and the State Department will be more comfortable with a wider U.S. role in caring for UN troops. This is indeed one area where the U.S. should be most proud as an integral part of the mission.⁹

Theater-wide medical planning also continued to evolve during Fleet Hospital Six's deployment. The U.S. Hospital worked hand and glove with the UNPROFOR FMEDO by conducting liaison visits with every Sector Medical Liaison Officer to assess their medical planning and operations; obtained and maintained current information in a database regarding every medical asset within the theater and produced a sector as well as a theater-wide medical asset availability report for use as a credible and valid reference by the SMEDLOs; and initiated the necessary actions to enhance health service support. They developed a standard package to assist SMEDLOs in the performance of their duties regarding medical operations and planning. The package contained checklists, sample SOPs, points to interface with sector staff on medical plans and operations, and various UNPROFOR documents that medical planners should have readily available to execute their responsibilities.¹⁰

CHAPTER IV

LESSONS LEARNED/RECOMMENDATIONS

Many lessons can be learned from our medical support to UNPROFOR. They can assist the CINCs and their staffs when planning and executing future peacekeeping operations and can certainly be added to lessons learned databases.

* As the services move to adapt to the changing world of joint and UN involvement, our military medical departments must adopt or make doctrinal changes to better support deployed forces. Medical support for UN peacekeeping operations, in particular our long-term medical commitment to UNPROFOR, reflects much of how we are currently operating and could be adapted as joint guidance for future U.S. participation in UN and coalition operations in the development and shaping of a coherent theater-wide medical strategy.

* With respect to UNPROFOR, all operational planning and coordination for medical support has taken place in-country. If the UN is to remain proactive, it is clearly going to have to develop eventually an integrated military staff so that it can develop its own capabilities. The need for a medical blueprint for coordinated combined operations is an essential end state. ¹

* The medical force must be tailored specifically for the mission. During the initial mission analysis, it is paramount to identify the military medical condition that must be created, the required steps to create the condition, and the necessary resources to accomplish the mission. Conditions for the success of planning guidance require clarity of purpose/mission, unity of command or unity of effort, clear political guidance in advance, one plan with annexes, detailed

intent, and operational sequencing (the phases of execution within the planning guidance of the deliberate planning process and crisis action planning).

- * If the U.S. wants to coordinate its medical capabilities with multinational forces or through the UN, the U.S. must develop a medical infrastructure to support lesser capable units in order to establish a base-line expectation of care throughout the theater of operations.

- * Representatives of humanitarian assistance organizations (PVOs and NGOs) should participate in combined planning with military and civilian government officials and participate in peacekeeping core group meetings. Sharing of information is crucial to effective joint planning and can also contribute to the formation of a joint doctrine. Military forces should take immediate advantage of the logistic, medical and infrastructure knowledge possessed by PVO/NGO operators.²

- * Military commanders are most comfortable with the articulation of a clear national objective. Armed forces readily provide command and control networks, security, logistics, medical support, leadership and authority. PVOs, NGOs and international organization personnel insist that their individual identities and mandates be respected. They have a fundamental belief that independence is key to neutrality, which is essential to their effectiveness. Thus PVOs and NGOs seek a transparency of purpose as much as military units seek a clarity of mission. Coordination is impossible unless objectives are similar; clarity helps to define objectives. It is essential to forge effective working relationships before PVOs, NGOs and military personnel are required to perform in the field.³

* Interoperability and flexibility remain critical as personnel must learn the basics of many jobs, learn to be part of several services, and learn to be an asset and a good will ambassador to many nations.

* Be particularly sensitive to maintaining neutrality and fairness if more than one ethnic, religious, armed or political group is part of the population being helped.

CHAPTER V

CONCLUSION

The ongoing hostilities in Bosnia have challenged the suitability of employing United Nations peacekeepers in this type of conflict. We have seen the divisive nature of members of the European Community, NATO and the United States, all of whom cannot agree as to the use of sanctions as well as the method of military force employment. There are no easy answers as the political and military context of this theater of operations makes it exceedingly difficult to define mission objectives and the desired end state.

Medical support to peacekeeping operations, however, is here to stay and should remain an integral part of the table of organization. Success or failure of peacekeeping operations may not ultimately rest on the provision of medical care but it can be stated with certainty that medical plays a pivotal role in preventing disease non-battle injuries (DNBI) from crippling a force, especially if the PKO is of a long duration.

Our political leadership must decide whether military intervention in peacekeeping operations is in the best interests of the United States, as spelled out in Presidential Decision Document-25. However, U.S. military medicine remains at the forefront of research and development; is able to exploit technological breakthroughs; is organizationally capable to support the mission; and is a low-cost, high benefit approach to maintaining our good will and leadership position in this new world order.

Accordingly, the Operational Art toolbox must contain a stethoscope to remind the commander that "medical" will always have a seat at the table.

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